

MEDICARE PART A

SECTION A

2010 MEDICARE PART A COVERED SERVICES AND COPAYMENTS

Services	Benefit	Medicare Pays	You Pay
Hospitalization Semi-private room and board, general nursing and other hospital services, and supplies. Medicare payments are based on benefit periods.	First 60 days	All but \$1,100 Per Benefit Period	\$1,100 Per Benefit Period
	Days 61-90	All but \$275/Day	\$275/per day
	Days 91-150	All but \$550/Day	\$550/per day
	Days 150+	Nothing	All Costs

Services	Benefit	Medicare Pays	You Pay
Skilled Nursing Facility Care Semi-private room and board, general nursing, skilled nursing rehabilitative services, other services and supplies. (Medicare payments are based on benefit periods)	First 20 days	100% aprvd.amt.	Nothing
	Additional 80 days	All but \$137.50 per day.	Up to \$137.50 per day
	Beyond 100 days	Nothing	All costs

Services	Benefit	Medicare Pays	You Pay
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited as long as you meet Medicare conditions	100% aprvd.amt.	Nothing
		80% for Durable Medical Equip. Approved amt.	20% Durable Medical Equip. Approved amt.

Services	Benefit	Medicare pays	You Pay
Hospice Care Pain relief, symptom management support services for the terminally ill.	Unlimited as long as doctor certifies the need	All but limited co-pay for outpatient drugs and inpatient respite care	Limited co-pay for out-patient drugs and inpatient respite care

Services	Benefit	Medicare Pays	You Pay
Blood	Unlimited if medically necessary	All but first three (3) pints per calendar year	For first (3) three pints if not replaced

2010 MEDICARE PART A COVERAGE AND PREMIUMS

2010 PREMIUM

Worked 40 quarters or more • Free
Worked 30-39 quarters • \$254 per month
Worked up to 30 quarters • \$461 per month

DEDUCTIBLES and CO-PAYMENT Hospital

2010 - Deductible per benefit period • \$1,100
Co-Pay for days 61-90 • \$275 per day
Co-Pay for days 91-150 • \$550 per day

Skilled Nursing Facility

Medicare pays in full for days 1-20
2010 Co-Pay for days 21-100 • \$137.50 per day

Blood

First 3 Pints Under Part A or B

Medicare Part A

Medicare Part A is often referred to as hospital insurance. When all requirements are met Part A helps pay for:

- **inpatient hospital** care (including critical access hospitals)
- limited coverage in a **skilled nursing** facility (but not custodial or long term care)
- full coverage for eligible **home health care**
- full coverage for eligible **hospice care**

Part A is usually free if you or your spouse have earned enough work credits (40 credits). About 99% of Medicare beneficiaries do not pay a premium for Part A.

If you are 65+ and have not earned 40 work credits, you are not eligible to receive Part A **premium-free**; however, you may **buy** Medicare Part A. In order to do so, you must be:

- a United States citizen or
- an alien lawfully admitted for permanent residence, and have lived in the U.S. for **five consecutive years** before applying for Medicare.

When buying Part A, you **must** also buy Part B (persons 65+ may not buy Medicare Part A only). If you decide to cancel Part B, your Part A will be lost.

If you are not sure if you have Part A, check your Medicare card. If you have Part A, you will find “HOSPITAL (PART A)” along with the effective date printed on your card.

INPATIENT HOSPITAL COVERAGE

Medicare Part A helps pay for Inpatient Hospital Care when **all** of the following conditions are met:

- A physician prescribes inpatient treatment of the illness or injury.
- The kind of care required can be provided only in a hospital.
- The hospital participates in Medicare.
- The hospital's Utilization Review Committee, the *Peer Review Organization*, (PRO) or the Medicare intermediary does not disapprove the stay.

Hospital Benefit Period

Medicare coverage of hospital care is measured in **BENEFIT PERIODS**, not based on a calendar year. A **hospital benefit period** begins the first day that you receive Medicare covered inpatient hospital services, and continues until you have been out of the hospital or skilled nursing facility for **60 consecutive days**.

The benefit period could continue if you are transferred from the hospital to another facility that provides **skilled nursing or rehabilitation services**. The benefit period ends when you have been out of the facility, or have not received skilled care in the facility, for 60 consecutive days.

A **new hospital benefit period** starts when inpatient hospital services are again required **after 60 consecutive days have passed** since you left the hospital or skilled care facility. You can experience more than one hospitalization during a benefit period for a different condition without a new deductible.

You can have more than one benefit period during a year, if the hospitalizations in a skilled facility are more than 60 days apart from discharge to admittance. **You must pay the Part A deductible each time** a new benefit period starts. The Part A deductible is the full amount you will pay for the first 60 days of inpatient hospital care. It is technically possible, (but unlikely) to have six (6) benefit periods in one year. You may have an unlimited total number of inpatient hospital care benefit periods during your lifetime, as **benefit periods are renewable**.

Hospital Deductible for Medicare Part A

You must pay the Part A deductible for each hospital benefit period.
Only one (1) deductible per benefit period may be charged by the hospital.

Services Covered by Medicare Part A During a Hospital Stay

- Semi-private room and board, including meals for special diets. A private room will be paid for only if medically necessary. Normally, telephones and television services are not covered if listed separately from the room charge.
- Special care units, such as intensive care or coronary care units.
- Regular nursing services, **not private duty nursing**.
- Drugs furnished by the hospital during the inpatient stay.
- Lab tests included in the hospital bill, which may include diagnostic tests provided up to 72 hours prior to admission, if the tests are related to the reason for admission.
- Radiology services included in the hospital bill, such as x-rays or radiation therapy.
- Medical supplies such as casts, splints and surgical dressings.
- Operating and recovery room costs.
- Use of medical appliances such as wheelchairs.
- Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services.
- Blood transfusions during a hospital stay, after the first three pints per calendar year. You must either pay for the first three pints of blood, have a donor replace them, or build a reserve prior to the need.

Doctor services received in a hospital are covered under Part B.

Medicare Part A payment for days 61 - 150 in a hospital

During the 61st-150th days of hospitalization, Medicare pays all covered hospital costs except for a daily charge, called **co-payment**. The hospital will bill the co-payment to you, or to your other insurance. Your daily co-payment for days 91-150 is higher than it is for days 61-90.

Lifetime Reserve Days

If hospitalization extends beyond **150 days**, you will be charged for the stay. You may pay the charges, or elect to use your **Lifetime Reserve Days** to have Medicare assist with payment.

With Medicare you have **60 extra days**, called **Lifetime Reserve Days**. These can be used only once in a lifetime, and only after you have used 90 inpatient hospital days. The hospital stay must still be Medicare approved, and Lifetime Reserve Days include a coinsurance for each day. For 2010, this co-payment is the same as the co-payment for days 91-150.

- Lifetime Reserve Days are **not renewable**. The use of these days can be spread out over several benefit periods, but can only be used once.
- You decide when to use the reserve days and how many to use within a given benefit period.
- Unless the hospital is **notified in writing** either upon admission, or up to 90 days after discharge, the hospital will assume that you want to use reserve days. You can have this decision reversed by contacting the hospital.

Care in a Psychiatric Hospital

Psychiatric care in a general hospital is treated the same as any other Medicare inpatient hospital care. **Psychiatric care in a freestanding psychiatric hospital is subject to a lifetime limit.**

Medicare Part A pays no more than 190 days of inpatient care in a freestanding Medicare participating hospital in a lifetime. Lifetime Reserve Days can be used for care received in a freestanding psychiatric hospital after Medicare has paid for 190 days of care.

Foreign Travel and Medicare

Outside the United States, Medicare will not pay for **any** services, except for services in certain emergency or distance related conditions. U.S. territories Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered a part of the United States.

Care in a Christian Science Sanitarium

Medicare pays for inpatient care received in a participating Christian Science sanitarium **if** it is operated or listed and certified by the First Church of Christ Scientist, in Boston. **Part B will not pay for the practitioner.**

For more information about Part A coverage in nonparticipating hospitals, or in hospitals outside the U.S., contact Medicare at 1-800-Medicare (1-800-633-4227).

How Medicare Pays Hospitals

Medicare reimbursement to hospitals is determined through the **Prospective Payment System (PPS)**. Hospitals are paid by the **diagnosis**, not by the length of the hospital stay, and payments are based on the average costs for treating a particular illness or injury. The various illness categories are called **Diagnosis Related Groups (DRGs)**.

In special cases where costs for necessary care are unusually high, or the length of stay is unusually long, Medicare **may** make extra payments to the hospital. **You are only responsible for the Part A deductible, the coinsurance, and the cost of any non-covered services.**

Discharge from a hospital occurs when the Diagnosis Related Group payment is exhausted, or when your condition stabilizes and other means of treatment are available.

You have the right to appeal a hospital's and/or Medicare's decision to deny coverage for inpatient hospital stays.

SKILLED NURSING FACILITY CARE

Medicare may help pay for **Skilled Nursing Facility (SNF) Care**. **Skilled Nursing Care** must be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services include physical therapy performed by, or under the supervision of, a professional therapist.

Custodial Care is help with **Activities of Daily Living (ADLs)**, or meeting personal needs, and can be provided safely and reasonably by people without professional skills or training. ADLs assistance may include help with walking, getting in and out of bed, bathing, dressing, and eating. **Medicare does not pay for custodial care when it is the primary kind of care needed.**

Medicare Requirements for Skilled Nursing Facility Care

To qualify for SNF coverage under Medicare Part A:

- You must be admitted to a **Medicare participating SNF** Medicare designated bed.
- Medicare Intermediary does not disapprove of the stay.
- Your condition requires **skilled nursing or skilled rehabilitation** services on a daily basis in a SNF, and a medical professional has certified that you need to receive this care.
- You must have spent **at least three (3) days in the hospital**, (not counting the day of discharge), before going to the SNF.
- Admission to an SNF **within 30 days** after leaving the hospital.
- Care in a SNF for a **condition that was treated in the hospital** or for a condition that arose while receiving care in the SNF.

Skilled Nursing Facility Benefit Period

Medicare Part A helps pay for a **maximum of 100 days** in a Skilled Nursing Facility in each benefit period. A benefit period begins the first day that you are transferred from a hospital to the SNF. If you are discharged from a SNF before using the 100 SNF days and are readmitted within 60 days, the same benefit period will continue. **A new benefit period will start only after you have been out of a skilled facility (SNF or hospital) for over 60 days.**

A new 3-day prior hospitalization would **only be required** when you have not received skilled care in a hospital or Skilled Nursing Facility for 31 days or more (even if still within the same benefit period) or when Medicare has paid for 100 days in a benefit period.

**You will not normally need 100+ days of Skilled Nursing Care.
Skilled Nursing Facility coverage is not meant for long term care.**

Major Services Covered by Medicare Part A During a Skilled Nursing Facility Stay

- Semi-private room and board, including special diets. **Private room if medically necessary.**
- Regular nursing services. **Not private duty nurses.**
- Doctor ordered physical, occupational, and speech therapy.
- Drugs furnished by the SNF during the stay including blood transfusions **after** the first three (3) pints per year.
- Use of medical equipment and supplies furnished by the Skilled Nursing Facility including wheel chairs, splints, casts, etc.

**Doctor services received in a SNF are covered under
Medicare Part B.**

HOME HEALTH COVERAGE

If you need **skilled health care** at home for treatment of an illness or injury, **Medicare pays 100% for all covered Home Health Care (HHC) services.**

Medicare Part A and Part B each pay for some parts of HHC. **If you have only Part B**, then Part B would pay for the HHC services; the Part B deductible would not apply.

In order for Medicare to cover HHC services, the agency must be Medicare participating, and provide skilled nursing care.

Home Health Care agencies should do a **free evaluation** to see if you qualify for Medicare HHC coverage. **Your physician** should refer you to a Medicare participating HHC agency.

Medicare Requirements for HHC

In order to receive Medicare Part A coverage of HHC benefits, you must meet the following qualifications:

- A physician determines the need and sets up a plan for HHC.
- You must be **confined to the home** (homebound), but not necessarily bed ridden. Ask the HHC agency where you can go.
- The care must be part-time or **intermittent skilled** care, and/or physical therapy or speech therapy. This benefit will cover eight (8) hours per day of reasonable and necessary care up to 21 consecutive days, or longer in certain cases (therapy up to 35 hours per week).
- The agency providing the services is a Medicare participating HHC agency. The **HHC agency submits all the claims for payment** and is paid directly by Medicare.
- **No prior hospitalization is required to receive covered HHC services.**

Services Covered During HHC Visits Include:

- Part-time or intermittent **skilled nursing care**.
- Physical and speech therapy.
- If receiving physical or speech therapy, Medicare will also pay for:
 - Occupational therapy.
 - Part-time or intermittent assistance with ADLs (bathing or changing of dressings) by home health aides.
- Medical social services.
- Medical supplies.
- Durable medical equipment (**subject to a 20% coinsurance**).

Services Not Covered During HHC Visits

The following services are **not** covered by Medicare in HHC:

- Drugs and biologicals that can be self-administered.
- Homemaker services such as laundry, meal preparation, shopping, or other chores.
- Meals delivered to the home.
- Blood transfusions.
- 24 hour/day nursing care at home. **Services provided by your relative or a member of the household.**

HOSPICE CARE COVERAGE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill patients. It can include both home and inpatient care, as well as a variety of services not normally covered under Medicare.

Medicare Requirements for Hospice Care

In order to receive Medicare Hospice benefits, you must meet the following conditions:

- A doctor must certify that you are **terminally ill** (diagnosed as having six (6) months or less to live if the illness runs its normal course).
- You choose to receive care from hospice **instead** of regular Medicare benefits for the terminal illness.
- The care must be through a Medicare participating hospice program.

Medicare will pay 100% for most covered hospice services. You may have to pay a **small coinsurance fee** for:

- Outpatient prescription drugs.
- Inpatient respite care (to provide some time off for the person who regularly provides care in the home), not to exceed five (5) days per stay.

Hospice programs can provide a few days of relief for family members who are caring for a terminally ill relative.

Special Benefit Period for Hospice Care

You may elect to receive hospice care for two 90 day benefit periods followed by an unlimited number of 60 day periods. The benefit periods may be used consecutively or at intervals. You must be certified as **terminally ill** at the **beginning** of each period.

You have the right to cancel hospice care at any time, and return to standard Medicare coverage, then later re-elect the hospice benefit. If you cancel hospice care during one of the benefit periods, any days left in that period are lost.

Services Covered Under Hospice

The following services under hospice are covered by Medicare:

- Doctor and nursing services.
- Home health aide and homemaker services.
- Short term inpatient care.
- Medical supplies and appliances.
- Physical, occupational and speech therapy.
- Drugs including outpatient medications for pain relief and symptom management, with a possible co-payment required.
- Counseling including bereavement counseling.
- Medical social services.

Other Illnesses and Hospice

If a patient requires treatment for a condition **not related to the terminal illness**, Medicare will help pay for all necessary covered services under the standard Medicare benefit program.